CONNECTICUT CENTER
FOR PATIENT SAFETY
QUALITY HEALTHCARE IS A RIGHT.

TO: MEMBERS OF THE PUBLIC HEALTH COMMITTEE

FROM: CONNECTICUT CENTER FOR PATIENT SAFETY

DATE: MARCH 1, 2010

PLEASE SUPPORT SENATE BILL 248—AAC ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES

The members of the Connecticut Center for Patient Safety (CCPS) respectfully request you to SUPPORT Senate Bill 248.

Current Connecticut Law requires certain hospitals and outpatient surgical facilities to report to the CT Department of Public Health certain adverse events that occur to patients in the care of these facilities. Importantly, the ***Hartford Courant*** reported in November 2009 that some Connecticut hospitals are underreporting the adverse events that occur in those hospitals (please see the attached 11/22/09 ***Courant*** Editorial). This is a dangerous problem which is addressed by Senate Bill 248.

- Section 1 of Senate Bill 248 improves Connecticut's current adverse event reporting law by adding a provision that requires the CT Department of Public Health to report to the Legislature's Public Health Committee the names of the hospitals where the adverse events occur. This will allow consumers to have more access to crucial public health information regarding certain patterns of problems (adverse events) that may be occurring in certain hospitals.

- Section 1 of the Senate Bill 248 also contains a provision to establish a "Random Audit" procedure, under which the DPH can randomly audit a hospital to investigate whether the hospital is complying with the adverse event reporting law. A Random Audit is generally a very successful and very cost-effective mechanism to ensure compliance with the law. For example, the Connecticut Office of State Ethics has a very successful random audit program in place. Every year, 40 lobbying entities, along with all of the entities' associated in-house and outside lobbyists, are randomly selected to have their business records audited by the Office of State Ethics. This process has encouraged and facilitated compliance with the State Ethics laws (in fact, the Connecticut Center for Patient Safety was audited last year). The audit process for lobbying entities and lobbyists is confidential, but the results of the audits are public and are subject to public review and inspection. We respectfully believe that it is a good idea for the CT DPH to similarly perform annual random audits on certain hospitals. This will encourage all hospitals to comply with the adverse event reporting law—just as the random audit process encourages compliance by lobbyists.

THANK YOU FOR YOUR SUPPORT OF SENATE BILL 248

OUR VIEW

IN THE DARK ABOUT DEATHS

Connecticut's hospitals invite public scorn when they refuse to disclose serious medical mistakes that kill or injure patients.

Courant writers Matthew Kauffman and Dave Altimari reported last Sunday that hospitals are failing to inform the state health department about dangerous lapses — such as the deaths of two 81-year-old women from accidental cuts at Hartford Hospital in 2005.

Just as troubling, the state investigates only one in four reported cases, keeping the others secret, including more than 50 in which patients died in recent years.

HOSPITAL 'ADVERSE EVENTS'

>> Mistakes, injuries go unreported

The General Assembly amended the "adverse event" law in 2004 to limit the types of cases that must be reported to those that health experts say should never occur in a hospital (such as leaving a sponge inside a patient after an operation). Legislative supporters hoped the change would result in more honest compliance with internal reviews to fix problems.

After the law took effect, filings of "adverse events" dropped by more than half. Hospitals are clearly keeping more of their mistakes to themselves. Even when they report medical errors, there is a good chance the state will do nothing. Shockingly, the state has failed to investigate sexual assaults in hospitals and egregious errors that resulted in death. Cases not investigated are automatically kept secret.

Attorney General Richard Blumenthal reacted to the disclosures with appropriate anger when he called the revised law "a deadly and disgraceful failure, shielding hospitals and medical professionals from scrutiny and accountability and leaving patients in the dark."

The state has not even tried to determine whether hospitals are following the amended law.

There is no excuse for this code of silence about patient outcomes. The state's hospitals, which usually provide outstanding medical care, damage their credibility when they cover up botched procedures, many of which become public only after a lawsuit is filed.

As noted by Jean Rexford, executive director of the nonprofit Connecticut Center for Patient Safety, hospitals would address lapses more quickly if the information was public. In her words, "Sunlight works and public shame also works."

The attorney general has vowed to seek legislation requiring greater disclosure and providing regulators with more resources and new authority to levy fines.

Fixing this broken reporting system must be a priority. The alternative is to keep the public in the dark, leading to cynicism about the state's hospitals and denying patients the right to see how hospitals perform.